Learning Unlimited- Fall 2024

Course Description: Ten sessions of independent living skills instruction related to leisure activities. Ex: Cooking, arts, craft, recreational activities, fine-arts, guest speakers, exercise, and community activities.

Instructors: Andrew Fowler & TBD

Dates: September 17, 23*, 30*
October 8, 15, 22, 29
November 4*, 12, 19

NOTE
September 23, September 30, & November 4th are Monday evenings

Time: 6:00 pm – 8:00 pm

Location: Monroe 2-Orleans BOCES Professional Development Center (Door #3)
3599 Big Ridge Road Spencerport, NY 14559
-or- various community locations

Participant Qualifications:

-Age 18+
-Resides within Monroe County
-Living at home with family/guardian
-Have a documented developmental disability & eligible for services through OPWDD
-Demonstrate socially acceptable behaviors
-Can remain in a classroom setting and accept instruction
-Ability to communicate needs to the instructor
-Be able to toilet independently or supply their own support which provides assistance
-NO MEDICAL STAFF ON SITE

RETURN REGISTRATION FORMS TO:

Email:
Andrew Fowler
afowler@monroe2boces.org

-or-

Mail:
Andrew Fowler
Monroe 2-Orleans BOCES
160 Wallace Way, Building 9
Rochester, NY 14624

CHECKLIST OF WHAT TO RETURN WHEN REGISTERING:

- **Registration Form**
- **Emergency Contact Form**
- **Medical Treatment Release Form**
- **Authorization to Disclose Protected Health Information (HIPPA)**

NEW PARTICPANTS ONLY:

- **Letter of Eligibility from OPWDD**

Please make sure all forms are completed and submitted together.

Registration Forms are due by September 1, 2024
****Late registrations will not be accepted****
****Space is limited, and will be granted on a first-come, first-served basis****

Registration Form for Learning Unlimited
Monroe 2-Orleans BOCES
Fall 2024

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Date of Birth: ____/____/_____

Parent/Guardian Email Address: _____

TABS #: _____

Service Coordinator Name: _____

Agency Phone: _____

Parent/Guardian Name: _____

Signature: _____

Allergies: _____

OPWDD Self-Directed: Yes _____ No _____

****

If the participant is coming with a 1:1 support staff, please provide their information below:

1:1 Support Staff Name: _____ Phone Number: _____

Email Address: _____ Employer: _____

****

****Please return this registration form with the letter of eligibility for OPWDD if new to the program.**

Please be aware that participants will not be accepted without this information. Enrollment is on a first-come, first-serve basis with priority given to new applicants. Participants need to re-register each session.

TRANSPORTATION: We are unable to provide transportation for participants. If you need assistance with transportation, please contact Maritza Cubi at Starbridge (mcubi@starbridgeinc.org) for information regarding the Go Monroe program which provides gas cards and Uber cards to eligible participants.

Emergency Contact Form for Learning Unlimited
Monroe 2-Orleans BOCES
Fall 2024

Participant Name: _____ Date: _____

Date of Birth: _____

Address: _____

_____
[city] [state] [zip]

Home Telephone: _____ Cell #: _____

Participant Email: _____

Parent/Gaurdian's Name(s): _____

Address: _____

_____
[city] [state] [zip]

Home Telephone: _____ Cell #: _____

Email: _____

Participant's Primary Physician: _____

Address: _____

_____
[city] [state] [zip]

INCASE OF EMERGENCY, PARTICIPANT MAY BE RELEASED TO THE FOLLOWING INDIVIDUAL(S):

_____ _____ _____
[name] [relationship] [telephone #]

_____ _____ _____
[name] [relationship] [telephone #]

Date: _____ Parent/Gaurdian Signature: _____

ANY CHANGES IN PERSONAL INFORMATION DURING THE YEAR, PLEASE NOTIFY LEARNING UNLIMITED STAFF AS SOON AS POSSIBLE.

Revised March 2014

Medical Treatment Release Form for Learning Unlimited
Monroe 2-Orleans BOCES
Fall 2024

PLEASE RETURN THIS FORM TO LEARNING UNLIMITED STAFF

I hereby give permission for my son/daughter _____
(participant name)
to receive emergency and/or non-emergency medical treatment in the event that I cannot be contacted and to provide consent for such treatment. I also give mt permission for an antidote to be administered to my child, after medical consultation, in the case of accidental swallowing of poisonous substance(s).

Child's Pediatrician: _____ Telephone #: _____

Address: _____

Hospital Preference (if necessary): _____

Health Problems (if any) (please specify): _____

_____

Medications (name, time, dosage): _____

_____

Allergies (if any) (please specify): _____

_____

Additional Comments: _____

_____

_____

Date: _____

_____
Name of Parent/Gaurdian

_____
Relationship to Participant

_____
Signature of Parent/Gaurdian

Revised March 2014

Your Educational Partner of Choice
BOCES 2
Monroe 2–Orleans Board of Cooperative Educational Services

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Federal law, Health Insurance Portability and Accountability Act (HIPAA) requires that this form be completed before protected health information regarding your child's care and treatment can be exchanged between BOCES and the child's health care provider. **Please read, sign, date this form, and return to your child's service provider.**

Student's Legal Name: _____ DOB: _____

Student is Also Known As: _____ Parent(s)/Guardian(s): _____

Home Address: _____ Phone Number(s): _____

_____ _____

HEALTH CARE PRACTICE OR PROVIDER:

Name of Practice: _____

Address: _____ Phone: _____

_____ Fax: _____

Protected Health Information (check all that apply)

- ☐ Immunization
- ☐ Health appraisals (e.g., physicals, evaluations)
- ☐ Entire medical record
- ☐ Mental health evaluations
- ☐ Discharge summary
- ☐ Service coordinator summary
- ☐ Behavioral data
- ☐ Other: _____

Purpose: This protected health information may be used and/or disclosed for the purpose of: **(check all that apply)**

- ☐ To develop care or therapy plans for routine and emergency school management
- ☐ To design appropriate educational, school, or athletic programs
- ☐ To assess the impact of the medical condition(s) on school programming and/or attendance
- ☐ To share school observations/concerns surrounding behavior
- ☐ To assess a medical basis for modification of transportation and/or home tutoring
- ☐ Medication delivery
- ☐ Therapy prescriptions
- ☐ Ongoing verbal communications between BOCES and the health care provider
- ☐ Other _____

Release to BOCES Employees

The protected health information about your child may be disclosed to any and all of the following BOCES staff including: medical officer, school physician, teacher, nurse, related service provider, administrator, or any other BOCES representative working with your child.

Validity Date: This authorization is valid for **(check one)**:

☐ _____ through _____ ☐ Will expire on _____ ☐ This request only, dated _____

I understand:

- I may revoke this authorization at any time by sending written notification to the privacy officer at my health care provider's office and/or BOCES, except where disclosure or action has been taken in reliance on this authorization.
- My signing of this consent form does not revoke other consents that have been signed and have not expired.
- My child's treatment and/or enrollment is not conditioned on this authorization.
- BOCES is an education institution which may redisclose this information in accordance with the Family Educational Rights and Privacy Act (FERPA).
- All of my questions on this form have been answered.

Authorization:

As the natural parent or legal guardian of the child, or as the non-minor student, I authorize the above health care provider(s) to disclose to BOCES 2 or receive from BOCES 2 the protected health information indicated above. I understand my signature is voluntary.

Parent or Legal Guardian Name	Relationship (if guardian)	Signature	Date

If age 18 years or over, Student Name		Signature, if age 18 or over	Date